		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0035782

Facility Name: Winston Manor Cnv & Nursing

Address: 2155 West Pierce (Number) Chicago (City) 60622 (Zip Code)

County: Cook

Telephone Number: (773) 252-2066 **Fax #** (773) 252-3688

IDPA ID Number: 363671711001

Date of Initial License for Current Owners: 01/01/1990

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Sanford B Alper **Telephone Number:** (847) 580-4100

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Sanford B Alper - Principal
Kessler, Orlean, Silver & Co. P.C.
(Firm Name & Address) 1101 Lake Cook Road. Suite C
Deerfield, Illinois 60015-5233
(Telephone) (847) 580-4100 Fax # (847) 580-4199

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 180

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	180	Intermediate (ICF)	180	65,700	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	180	TOTALS	180	65,700	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	59,192	425		59,617	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	59,192	425		59,617	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.74%

D. How many bed-hold days during this year were paid by Public Aid?
684 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/1990

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 1989 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified ____ and days of care provided 0

Medicare Intermediary Mutual Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2001 Fiscal Year: 12/31/2001

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	203,589	64,308	8,880	276,777		276,777	(146)	276,631			1
2	Food Purchase		173,464		173,464	(25,751)	147,713		147,713			2
3	Housekeeping	157,710			157,710		157,710		157,710			3
4	Laundry		4,421	13,057	17,478		17,478		17,478			4
5	Heat and Other Utilities			95,375	95,375		95,375		95,375			5
6	Maintenance	9,446	37,122	3,600	50,168		50,168		50,168			6
7	Other (specify):* See Attached Sch			19,117	19,117		19,117		19,117			7
8	**TOTAL General Services**	370,745	279,315	140,029	790,089	(25,751)	764,338	(146)	764,192			8
	B. Health Care and Programs											
9	Medical Director			1,800	1,800		1,800		1,800			9
10	Nursing and Medical Records	809,802	13,360	4,312	827,474		827,474		827,474			10
10a	Therapy			7,643	7,643		7,643		7,643			10a
11	Activities	60,413	20,721		81,134		81,134		81,134			11
12	Social Services	40,000		2,956	42,956		42,956		42,956			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	910,215	34,081	16,711	961,007		961,007		961,007			16
	C. General Administration											
17	Administrative	154,319			154,319		154,319		154,319			17
18	Directors Fees											18
19	Professional Services			25,425	25,425		25,425	(704)	24,721			19
20	Dues, Fees, Subscriptions & Promotions			19,787	19,787		19,787		19,787			20
21	Clerical & General Office Expenses	206,128		79,120	285,248		285,248	(39,917)	245,331			21
22	Employee Benefits & Payroll Taxes			265,703	265,703	25,751	291,454	11,084	302,538			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,334	1,334		1,334		1,334			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			48,475	48,475		48,475		48,475			26
27	Other (specify):*											27
28	**TOTAL General Administration**	360,447		439,844	800,291	25,751	826,042	(29,537)	796,505			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,641,407	313,396	596,584	2,551,387		2,551,387	(29,683)	2,521,704			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Winston Manor Cnv & Nursing #0035782 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			36,392	36,392		36,392	41,359	77,751			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			85	85		85	(85)				32
33	Real Estate Taxes							79,351	79,351			33
34	Rent-Facility & Grounds			462,851	462,851		462,851	(462,851)				34
35	Rent-Equipment & Vehicles			13,555	13,555		13,555		13,555			35
36	Other (specify):*											36
37	**TOTAL Ownership**			512,883	512,883		512,883	(342,226)	170,657			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			98,550	98,550		98,550		98,550			42
43	Other (specify):* Trust Fees			250	250		250	(250)				43
44	**TOTAL Special Cost Centers**			98,800	98,800		98,800	(250)	98,550			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,641,407	313,396	1,208,267	3,163,070		3,163,070	(372,159)	2,790,911			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(9,547)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(146)	1		13
14	Non-Care Related Interest	(85)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(4,389)	21		18
19	Entertainment				19
20	Contributions	(37,400)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,085)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (52,652)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(319,507)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (319,507)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (372,159)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Winston Manor Cnv & Nursing

ID# 0035782

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Collections	$ (835)	19	1
2	Trust Fees	(250)	43	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,085)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(146)	0	0	0	0	0	0	0	0	0	0	(146)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(146)	0	0	0	0	0	0	0	0	0	0	(146)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(835)	131	0	0	0	0	0	0	0	0	0	(704)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(41,789)	1,872	0	0	0	0	0	0	0	0	0	(39,917)	21
22	Employee Benefits & Payroll Taxes	0	11,084	0	0	0	0	0	0	0	0	0	11,084	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(42,624)	13,087	0	0	0	0	0	0	0	0	0	(29,537)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(42,770)	13,087	0	0	0	0	0	0	0	0	0	(29,683)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(9,547)	0	50,906	0	0	0	0	0	0	0	0	41,359	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(85)	0	0	0	0	0	0	0	0	0	0	(85)	32
33	Real Estate Taxes	0	0	79,351	0	0	0	0	0	0	0	0	79,351	33
34	Rent-Facility & Grounds	0	0	(462,851)	0	0	0	0	0	0	0	0	(462,851)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(9,632)	0	(332,594)	0	0	0	0	0	0	0	0	(342,226)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(250)	0	0	0	0	0	0	0	0	0	0	(250)	43
44	**TOTAL Special Cost Centers**	(250)	0	0	0	0	0	0	0	0	0	0	(250)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(52,652)	13,087	(332,594)	0	0	0	0	0	0	0	0	(372,159)	45

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Marvin Mermelstein	75.00%	Balmoral Home, Inc.	Chicago, IL	Nivram Mgmt., Inc.	Chicago, IL	Nursing Home
Joseph Mermelstein	25.00%	Emerald Park Nursing Center	Evergreen Park, IL			Management
		Central Nursing Home, Inc.	Chicago, IL	Pierce Building Ptsp	Chicago, IL	Lessor
		Sovereign Healthcare, L.L.C.	Chicago, IL			
		Chicago Ridge Nursing and Rehab Center	Chicago, IL			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	Bank Charges	$	Nivram Management, Inc.	50.00%	$ 89	$ 89	1
2	V	21	Office Expenses		Nivram Management, Inc.	50.00%	156	156	2
3	V	21	Supplies		Nivram Management, Inc.	50.00%	1,138	1,138	3
4	V	22	Payroll Tax		Nivram Management, Inc.	50.00%	11,084	11,084	4
5	V	21	Telephone		Nivram Management, Inc.	50.00%	480	480	5
6	V	19	Accounting		Nivram Management, Inc.	50.00%	131	131	6
7	V	21	Franchise Tax		Nivram Management, Inc.	50.00%	9	9	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$ 13,087	$ * 13,087	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	Depreciation	$	Pierce Building Partnership	50.00%	$ 50,906	$ 50,906	15
16	V	33	Property Taxes		Pierce Building Partnership	50.00%	79,351	79,351	16
17	V	34	Rent	462,851	Pierce Building Partnership	50.00%		(462,851)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 462,851			$ 130,257	$ * (332,594)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Henry Mermelstein	Administrator	Administrative	None	183,690	15	18.36%	Salary	$ 41,310	L17,C1	1
2	Louise Mermelstein	Dietary Supervisor	Support	None	57,600	22	28.00%	Salary	22,400	L1,C1	2
3	Marvin Mermelstein	Plant Supervisor	Support	50.00%	42,004	3	18.36%	Salary	9,446	L6,C1	3
4	Doreen Mermelstein	Administrative Asst.	Clerical	None	77,558	11	18.36%	Salary	17,442	L21,C1	4
5											5
6	Marvin Mermelstein	Asst. Administrator	Administrative	See Above	158,014	5	18.36%	Salary	35,536	L17,C1	6
7	Joseph Mermelstein	Owner	Administrative	50.00%	61,200	3	28.00%	Salary	23,800	L17,C1	7
8											8
9		See Schedule B									9
10											10
11											11
12											12
13								TOTAL	$ 149,934		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Nivram Management, Inc.
Street Address: 2155 W. Pierce
City / State / Zip Code: Chicago, IL 60622
Phone Number: (773) 252-3208
Fax Number: (773) 252-3688

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Bank Charges	Resident Beds	980	6	$ 485	$ 0	180	$ 89	1
2	21	Office Expense	Resident Beds	980	6	851	0	180	156	2
3	21	Supplies	Resident Beds	980	6	6,194	0	180	1,138	3
4	22	Payroll Tax	Resident Beds	980	6	60,345	0	180	11,084	4
5	21	Telephone	Resident Beds	980	6	2,615	0	180	480	5
6	19	Accounting	Resident Beds	980	6	713	0	180	131	6
7	21	Franchise Tax	Resident Beds	980	6	50	0	180	9	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 71,253	$		$ 13,087	25

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	Miscellaneous										85	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 85	14
15	TOTALS (line 9+line14)						$	$			$ 85	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 191,600	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 133,451	2
3. Under or (over) accrual (line 2 minus line 1).		$ (58,149)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 137,500	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 79,351	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	135,873	8
	1997	156,540	9
	1998	136,928	10
	1999	185,991	11
	2000	133,451	12

2000 Tax Bill = 133,451
Est Increase = 1.03
Est 2000 Tax = 137,455 use 137,500

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Winston Manor Cnv & Nursing COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0035782

CONTACT PERSON REGARDING THIS REPORT Sanford B Alper

TELEPHONE (847) 580-4100 FAX #: (847) 580-4199

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	17-06-106-001-0000	Winston Nursing Home	$ 133,451.00	$ 133,451.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 133,451.00	$ 133,451.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 59,192 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 4

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home		1989	$ 105,000	1
2					2
3	TOTALS			$ 105,000	3

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	180		1989		$ 1,536,832	$	31.5	$ 48,779	$ 48,779	$ 542,775	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Security System			1990	9,200	292	31.5	292		3,468	9
10	Interior Improvement			1990	32,039	1,018	31.5	1,018		11,745	10
11	Elevator			1990	5,300	168	31.5	168		1,925	11
12	Tiling & Lobby Office			1990	10,143	322	31.5	322		3,637	12
13	Building Improvements			1991	3,230	103	31.5	103		1,080	13
14	Building Improvements			1991	4,806	153	31.5	153		1,593	14
15	Tiles			1991	11,906	377	31.5	377		3,802	15
16	Radiator Cover			1992	12,400	394	31.5	394		3,858	16
17	Electrical Work			1992	3,500	111	31.5	111		1,078	17
18	Building Improvements			1993	21,476	550	39	550		4,616	18
19	Building Improvements			1995	34,754	891	39	891		5,829	19
20	Flooring & Tile			1996	5,355	137	39	137		759	20
21	Generator			1996	35,589	913	39	913		5,060	21
22	Air Conditioner			1996	16,511	423	39	423		2,345	22
23	Alarm System			1996	3,744	96	39	96		532	23
24	Roof			1996	1,200	31	39	31		172	24
25	Hot Water Heater			1996	2,900	74	39	74		410	25
26	Smoke Eaters			1993	4,600		10	460	460	3,450	26
27	Air Conditioner			1993	2,550		10	255	255	1,912	27
28	Carpet			1993	3,527		10	353	353	2,648	28
29	Boiler			1993	3,600		10	360	360	2,700	29
30	Air Conditioner			1994	5,122		10	512	512	3,328	30
31	Hot Water Heater			1995	4,160		10	416	416	2,292	31
32	Air Conditioner			1995	2,816		10	282	282	1,559	32
33	Glass			1995	647		10	64	64	320	33
34	Roof			1997	21,350	547	39	547		2,462	34
35	Phone System			1997	13,666	350	39	350		1,575	35
36	Electrical Work			1997	49,685	1,274	39	1,274		5,733	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Central Air Conditioning	1997	$ 35,499	$ 910	39	$ 910	$	$ 4,095	37
38	New Office Construction	1997	4,442	114	39	114		513	38
39	Boiler Insulation / Installation	1997	29,412	754	39	754		3,393	39
40	Fire Alarm and Sprinklers	1997	2,475	63	39	63		284	40
41	Doors and Constraction	1997	8,191	210	39	210		945	41
42	Pmumbing - Toilets, Popes	1997	4,719	121	39	121		545	42
43	Roof	1998	3,900	100	39	100		350	43
44	HVAC Work	1998	2,700	69	39	69		242	44
45	Doors and Constraction	1998	2,729	70	39	70		245	45
46	Time Clock	1998	5,244	135	39	135		347	46
47	Air Conditioner	1998	777	20	39	20		70	47
48	Phone System	1998	1,283	33	39	33		121	48
49	Door	1999	2,500	64	39	64		97	49
50	Fire Damper	1999	1,783	46	39	46		69	50
51	Water System	1999	6,000	154	39	154		231	51
52	Doors and Constraction	1999	2,500	64	39	64		64	52
53	Kitchen Tiling	1999	10,250	263	39	263		394	53
54	New Windows	2001	1,300	9	39	17	8	167	54
55	Door and Frame	2001	2,055	13	39	26	13	26	55
56	Electric Wiring	2001	443	3	39	6	3	6	56
57	Wall Repair	2001	1,000	11	39	13	2	13	57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,991,810	$ 11,450		$ 62,957	$ 51,507	$ 634,880	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 153,466	$ 12,573	$ 14,175	$ 1,602	5-10 Yrs	$ 103,373	71
72	Current Year Purchases	12,369	12,369	619	(11,750)	10 Yrs	619	72
73	Fully Depreciated Assets	317,222					317,222	73
74								74
75	TOTALS	$ 483,057	$ 24,942	$ 14,794	$ (10,148)		$ 421,214	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,579,867	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 36,392	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 77,751	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 41,359	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,056,094	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 2,951 Description: Ice Maker - $825, Copier - $2,126
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Administrative	1996 Chrysler Van	$ 388.00	$ 3,880	17
18	Administrative	1996 Jeep Cherokee	420.00	4,200	18
19	Administrative	2002 Jeep Cherokee	500.00	1,143	19
20	Administrative	2002 Chevrolet	613.00	1,381	20
21	TOTAL		$ 1,921.00	$ 10,604	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 78,037	$ 78,037	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	887,980	887,980	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	143,869	143,869	7
8	Accounts Receivable (owners or related parties)	671,247	1,235,535	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,781,133	$ 2,345,421	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		105,000	13
14	Buildings, at Historical Cost		1,536,832	14
15	Leasehold Improvements, at Historical Cost	427,956	502,661	15
16	Equipment, at Historical Cost	510,073	510,073	16
17	Accumulated Depreciation (book methods)	(554,792)	(1,164,899)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Deposits	500	500	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 383,737	$ 1,490,167	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,164,870	$ 3,835,588	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 42,773	$ 42,773	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	54,559	54,559	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		137,500	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	22,018	22,018	35
	Other Current Liabilities(specify):			
36	See Schedule 17A	1,702,221	1,702,221	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,821,571	$ 1,959,071	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,821,571	$ 1,959,071	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 343,299	$ 1,876,517	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,164,870	$ 3,835,588	48

*(See instructions.)

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 587,377	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 587,377	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,680,922	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,925,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (244,078)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 343,299	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,798,375	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,798,375	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,645	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 12,645	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6,966	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6,966	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Attached Schedule E	81,889	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 81,889	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,899,875	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	790,089	31
32	Health Care	961,007	32
33	General Administration	800,291	33
	B. Capital Expense		
34	Ownership	512,883	34
	C. Ancillary Expense		
35	Special Cost Centers	250	35
36	Provider Participation Fee	98,550	36
	D. Other Expenses (specify):		
37	Trust Fees	250	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,163,320	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,736,555	41
42	**Income Taxes**	(55,883)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,680,672	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,189	1,333	$ 36,451	$ 27.35	1
2	Assistant Director of Nursing	1,264	1,415	29,074	20.55	2
3	Registered Nurses	8,427	8,493	145,827	17.17	3
4	Licensed Practical Nurses	9,248	9,744	137,651	14.13	4
5	Nurse Aides & Orderlies	50,123	53,967	431,639	8.00	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,080	2,080	29,160	14.02	8
9	Activity Director	1,604	1,820	15,189	8.35	9
10	Activity Assistants	6,746	7,411	45,224	6.10	10
11	Social Service Workers	2,080	2,080	40,000	19.23	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,013	2,269	32,484	14.32	14
15	Cook Helpers/Assistants	19,369	20,953	171,105	8.17	15
16	Dishwashers					16
17	Maintenance Workers	172	172	9,446	54.92	17
18	Housekeepers	21,623	22,520	157,710	7.00	18
19	Laundry					19
20	Administrator	2,080	2,080	53,673	25.80	20
21	Assistant Administrator	258	258	35,536	137.74	21
22	Other Administrative	939	939	65,110	69.34	22
23	Office Manager					23
24	Clerical	18,288	18,915	206,128	10.90	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	147,503	156,449	$ 1,641,407 *	$ 10.49	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 8,880	L1,C3	35
36	Medical Director	Monthly	1,800	L9,C3	36
37	Medical Records Consultant	Monthly	2,552	L10,C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,760	L10,C3	39
40	Physical Therapy Consultant	77	3,526	L10A,C3	40
41	Occupational Therapy Consultant	76	3,496	L10A,C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1	46	L10A,C3	43
44	Activity Consultant				44
45	Social Service Consultant	78	2,956	L12,C3	45
46	Other(specify)				46
47	Psychosocial Consultant	13	575	L10A,C3	47
48					48
49	TOTAL (lines 35 - 48)	245	$ 25,591		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Arleen Batorek	Administrator	0.00%	$ 53,673
Marvin Mermelstein	Asst. Administr	75.00%	35,536
Henry Mermelstein	Administrative	0.00%	41,310
Joseph Mermelstein	Administrative	0.00%	23,800
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 154,319

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Kessler, Orlean, Silver & Co.	Accounting	$ 10,200
Immigration & Naturarlization	Registration Service	460
Branda Cohen	Collections	835
N.H.P.S.	Employement Agency	3,600
Richard Peelo & Assoc.	Accounting	375
Personal Planner, Inc.	U/C Consultant	1,090
See Attached Schedule	Legal	8,865
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 25,425

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 56,113
Unemployment Compensation Insurance	11,939
FICA Taxes	98,998
Employee Health Insurance	71,558
Employee Meals	25,751
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Head Tax	3,782
Other Employees Benefit	23,313
Allocation from Management Company	11,084
TOTAL (agree to Schedule V, line 22, col.8)	$ 302,538

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	11,531
Health Care Worker Background Check	
(Indicate # of checks performed 16)	112
IL DEPARTMENT OF PROF REG	100
IL COUNCIL ON LONG TERM CARE	3,542
SECRETARY OF STATE	284
CHICAGO DEPARTMENT OF REV	1,688
HCFA LAB PROGRAM	150
CITY OF CHICAGO	2,380
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,787

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,334
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,334

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council on Long Term Care $3,542**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7.5 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **N/A**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **98,550**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **25,751** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Adequate Records are Maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees